or discharge may not have been completed prior to the facility's planned date of termination from the medicaid program.

(c) Providers terminating participation in the medicaid program must prepare and file, in accordance with applicable cost reporting rules, a close out cost report covering the period from the end of the provider's previous fiscal year through the date of termination from the program. New providers assuming operation of a facility from a terminating provider must enroll in the medicaid program in accordance with applicable rules.

(4) A provider must notify a resident or the resident's representative of a transfer or discharge as required by 42 CFR 483.12(a)(4), (5) and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend or other spokesperson. Notice forms are available upon request from the department. Requests for notice forms may be made to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113 and 53-6-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the medicaid recipient's patient contribution. The per diem rate shall be subject to the maximum level, if any, specified in (3) through (3)(c). Except as provided in (4), the per diem rate is the sum of the following components:

(a) an operating cost component, individually determined for each provider in accordance with ARM 37.40.313;

(b) a direct nursing personnel cost component, individually determined for each provider in accordance with ARM 37.40.314; and

(c) a calculated property cost component, individually determined for each provider in accordance with ARM 37.40.323.

(2) For purposes of (1), medicaid patient days include bed hold days to the extent allowable under ARM 37.40.338.

(3) A provider's per diem rate for rate year 1992 shall neither exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus $8.00 per diem, nor be less than the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus 5.5% of such 1991 rate.

(a) A provider's per diem rate for rate year 1993 shall not exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1992 plus $9.00 per diem.

(b) A provider's per diem rate for rate years beginning on or after July 1, 1993 shall not be subject to any minimum or maximum amount of increase from the provider's previous rate or previous average rate.

(c) A provider's per diem rate effective July 1 of the rate year and throughout the rate year shall not exceed the provider's average per diem private pay rate for a semi-private bed, plus the average cost, if any, of items separately billed to private pay residents, in effect on July 1 of the rate year as specified by the provider in the department's survey of private pay rates conducted annually between April 1 and July 1 prior to the rate year. Providers who do not respond to the department's survey by July 1 of the rate year, will be subject to withholding of their medicaid reimbursement in accordance with ARM 37.40.346. The rate specified by the provider in this survey will be referred to as the reported rate.

(i) Upon request, providers must provide the department or its agents with records and information regarding the private pay rates charged to residents. If the department determines after desk review or audit that the provider has decreased the reported private pay rate or that the provider has in fact customarily charged private paying residents less than the reported rate, the department will decrease the provider's medicaid per diem rate, retroactive to July 1 of the rate year, to the amount of the decreased or actual private pay rate customarily charged to private paying residents during the rate year. The department will decrease the medicaid rate only if the decreased amount of the average private pay rate and separately billed items is lower than the computed medicaid rate. Any overpayment will be collected as provided in ARM 37.40.347.

(ii) The medicaid per diem rate will not be increased as a result of increases in private pay rates from the private pay rate in effect on July 1 of the rate year as specified in the department's survey described in (c).

(4) For providers which, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in ARM 37.40.325, the per diem rate shall be as provided in ARM 37.40.326.

(5) For ICF/MR services provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider as provided in ARM 37.40.336.

(6) In addition to the per diem rate provided under (1) or the reimbursement allowed to an ICF/MR provider under (5), the Montana medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.

(7) For nursing facility services, including ICF/MR services, provided by nursing facilities located outside the state of Montana, the Montana medicaid program will pay a provider only as provided in ARM 37.40.337.

(8) The Montana medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(9) Reimbursement for medicare co-insurance days will be as follows:

(a) for dually eligible medicaid and medicare individuals, reimbursement is limited to the per diem rate, as determined under (1) or ARM 37.40.336, or the medicare co-insurance rate, whichever is lower, minus the medicaid recipient's patient contribution; and

(b) for individuals whose medicare buy-in premium is being paid under the qualified medicare beneficiary (QMB) program under ARM 37.83.201 but are not otherwise medicaid eligible, payment will be made only under the QMB program at the medicare coinsurance rate.

(10) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(11) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(12) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized medicaid recipients during the billing period.

(a) Authorized medicaid recipients are those residents determined eligible for medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq. and 46.12.1101.

(13) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or non-payment, as specifically provided in these rules. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.308 RATE EFFECTIVE DATES (1) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the median operating costs or the statewide median average wage, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically for a rate methodology for the rate year.

(b) After the department has determined the median operating costs under ARM 37.40.313 and the statewide median average wage under ARM 37.40.314 for a rate year and has established provider rates based upon those determinations, the median operating costs and the statewide median average wage will not be revised or redetermined, except as provided in (1)(c), regardless of changes in provider costs resulting from base period cost report adjustments or other causes.

(c) The median operating costs under ARM 37.40.313 and the statewide median average wage under ARM 37.40.314 used to establish rates for a rate year will be redetermined only as required to set new rates for all providers for a subsequent rate year based upon adoption of further rules or amendments to these rules providing specifically for a rate methodology for a new or a subsequent rate year.

(2) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this subchapter, until the earlier of:

(a) the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year;

(b) the effective date of a change in the provider's operating cost component:

(i) as specified in the department's notice of final settlement of a cost report based upon a desk review or audit which results in

adjustment of the base period operating costs used by the department to calculate the provider's operating cost component; or

(ii) as provided in ARM 37.40.326;

(c) the effective date of a change in the provider's direct nursing personnel cost component:

(i) as specified in the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period direct nursing personnel costs used by the department to calculate the provider's direct nursing personnel cost component; or

(ii) as provided in ARM 37.40.326; or

(d) the effective date of a change in the provider's property cost component:

(i) upon certification of newly constructed beds as provided in ARM 37.40.323(4);

(ii) upon completion of an extensive remodeling (as defined in ARM 37.40.302) as provided in ARM 37.40.323(5);

(iii) as specified in the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period property costs used by the department to calculate the provider's property cost component; or

(iv) as provided in ARM 37.40.326. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

Rules 09 through 12 reserved

37.40.313 OPERATING COST COMPONENT (1) This rule specifies the method used by the department to calculate the operating cost component for a specific provider. Such operating cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the operating cost component for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if

available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

(b) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

(c) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. For the period July 1, 1999 through December 31, 1999, operating costs will be indexed at 75% of the DRI rate of inflation in order to offset the additional funding for the direct care wage add-on as provided in ARM 37.40.361 which is outside the per diem rate calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 37.40.308.

(d) "Median operating costs" means the median amount calculated by arraying the inflated per diem base period operating cost of each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have per diem costs less than or equal to the median and one-half of the licensed beds in the array have per diem costs greater than or equal to the median.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least 6 months with respect to the base period specified in (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the median operating costs. A cost report which is not timely filed in accordance with ARM 37.40.346 as of April 1 immediately preceding the rate year shall not be considered filed for purposes of inclusion in the array.

(ii) In determining median operating costs for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated per diem base period operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year.

(e) "Operating costs" means allowable patient-related administrative costs (including home office and management fees), dietary, laundry, housekeeping, plant operation, social services, activities, insurance and taxes, other than employment related insurance and taxes that are direct nursing personnel costs as defined

in ARM 37.40.314, and all other allowable direct and indirect patient-related costs, subject to the provisions of ARM 37.40.345, which are not direct nursing personnel costs, as defined in ARM 37.40.314, or property costs, as defined in ARM 37.40.323.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, operating costs shall not include nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA.

(f) "Per diem operating costs" means the provider's total operating costs divided by the number of provider's patient days for the base period.

(3) The provider's operating cost component is the lesser of the provider's inflated base period per diem operating costs or the operating cost limit calculated in accordance with (4), plus an incentive allowance, if applicable, as provided in (5).

(a) In determining the provider's operating cost component for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated base period per diem operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year.

(4) The operating cost limit is 99% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of 5% of median operating costs or 5% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

(a) In determining the amount of any incentive allowance to which the provider may be entitled under (5) for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated base period per diem operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.314 DIRECT NURSING PERSONNEL COST COMPONENT

(1) This rule specifies the method used by the department to calculate the direct nursing personnel cost component for a specific

provider. Such nursing cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's same cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the providers operating cost component for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

(b) "Composite nursing wage rate" means the total base period direct nursing personnel cost divided by the product of the providers fiscal year 1999 average patient assessment score and the provider's patient days for the base period.

(i) For purposes of calculating the composite nursing wage rate, the provider's base period average patient assessment score is the fiscal year 1999 average patient assessment score that was previously determined by the department in accordance with rules in effect for that period.

(c) "Direct nursing personnel cost" means allowable direct nursing personnel wages, salaries and benefits, to the extent such are direct costs of patient-related services actually rendered within the facility and are separately identifiable, rather than merely allocable, as such. Direct nursing personnel costs include the accrued wages, salaries and benefits of direct nursing personnel, to the extent such wages, salaries and benefits meet the other requirements of this definition and subject to the provisions of ARM 37.40.345. For purposes of this subchapter, direct nursing personnel include only registered nurses, licensed practical nurses, nurse aides, and, to the extent engaged in actual patient care rather than nursing administration, the director of nursing.

(d) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

(e) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year,

according to the DRI-HC. Direct nursing costs will not be indexed by the DRI rate of inflation for the period July 1, 1999 through December 31, 1999 to offset the additional funding for the direct care wage add-on as provided in ARM 37.40.361 which is outside the per diem rate calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 37.40.308.

(f) "Statewide median average wage" means the amount calculated by arraying the inflated base period average wage rate for each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have average wage rates less than or equal to the median and one-half of the licensed beds in the array have average wage rates greater than or equal to the median.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least 6 months with respect to the base period specified in (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the statewide median average wage. A cost report which is not timely filed in accordance with ARM 37.40.346 as of April 1 immediately preceding the rate year shall not be considered filed for purposes of inclusion in the array.

(3) The provider's direct nursing personnel cost component is the lesser of the provider's inflated base period composite nursing wage rate multiplied by the provider's fiscal year 1999 average patient assessment score or the direct nursing personnel cost limit calculated in accordance with (4).

(4) The direct nursing personnel cost limit is 99% of the statewide median average wage, multiplied by the provider's 1999 average patient assessment score, determined in accordance with the rules in effect for that period. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.315 PATIENT ASSESSMENT, STAFFING AND REPORTING

(1) For purposes of determining rate year 2000 rates, the provider's average patient assessment score will be the patient assessment score that was established for fiscal year 1999 rate

setting proposes in accordance with the rules in effect during that period.

(2) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate form DPHHS-SLTC-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-SLTC-015 may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(b) If complete and accurate copies of form DPHHS-SLTC-015 are not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-108, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Rules 16 through 19 reserved

37.40.320 MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION (1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the health care financing administration (HCFA) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health and human services. Back up tapes of each rate setting period will be maintained for a period of 5 years.

(4) Assessments not containing sufficient in-range data to perform a resource utilization group-III (RUG-III) algorithm will be assigned to the non-classifiable category of BC1. Non-classifiable assessments may be replaced following the HCFA policy for correction of a prior assessment. This replacement assessment shall be completed and transmitted to the HCFA database maintained by the department prior to the first Friday of the third month of each quarter to be included in the rate calculation. A default case mix index of the lowest index in the state will be assigned to all non-classifiable, BC1, assessments.